EXHIBIT E

UNITED STATES BANKRUPTCY COURT

FOR THE DISTRICT OF DELAWARE

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In re: :Chapter 11

FEDERAL-MOGUL GLOBAL, :Case No. 01-1-578 (RTL)

INC., et al., :Jointly Administered

Debtors. :

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Deposition of Mark A. Peterson, Ph.D.

Washington, D.C.

Friday, December 3, 2004

Pages 1 - 288

Job No.: 164539

Reported by: Deborah Larson Hommer, RPR

A. I have a problem with your word "start." It's ambiguous. I start my analysis with the values on page 57. The values on page 57 were derived from the scheduled values adjusted for inflation. Now, "start" can apply -- your word "start" can go to either of those places.

Actually, I don't even start there, though. I start with the analyses that are in section 6.1 of my report. There is an extensive discussion where I talk about estimating what the current values of the liabilities of Turner & Newall are. And I derive on page 15 three alternative estimates of what those current values are. And I truly start with those, and then I look to the scheduled values as a conservative alternative to those values.

So if you want to get to the start -- I mean, I start with the data that's in the Turner & Newall's database, and I start with the experience of other -- of Turner &

Newall and other companies with regard to the relative values of disease claims for different diseases. I start with a consideration of all the factors that are affecting the liabilities, and I end up with all -- in that calculation, as a matter of both convenience and conservatism, using the scheduled values.

Q. If I were going to try and create a mathematical formula to derive your forecast numbers in Table 39, page 57 of your report, what does that formula look like -- or equation, if you want to call it an equation?

A. That's a more precise question. Page 16, Table 7 of scheduled values for the TDP. Page 17, Table 8 is the scheduled value for mesothelioma and other cancers. The lung cancer and nonmalignant values there represent the weighted averages of the lung cancer claimants that would be in the two lung cancer categories, the nonmalignant claimants in three categories. So Table 8 is derived from

Table 7, plus assumptions about the distributions of the number of claimants that would be in the two lung cancer and three nonmalignant categories.

You take those numbers on Table 8 and you adjust for the actual inflation between 2001 and 2004. When you've made that adjustment for inflation, you then obtain the results that are shown on page 57, 39 that you asked me about -- Table 39.

Q. And the first thing you pointed me to in that equation was the scheduled TDP values on Table 7, page 16 of your report?

A. The first step in the specific quantification of those numbers begins with Table 7, page 16. But that's just the end of a lot of steps used in estimating what the current values are. And it is the end of -- because it's a number that has been already provided and agreed to and accepted by the plan proponents, and it's a conservative estimate of the current values.

Q. Your view is it's conservative?
A. I can only speak for myself here.
Q. That's your opinion, right?
A. It's my opinion.
Q. Let me just go through and make sure I have a general understanding of the methodology that you've used to make your estimate here. I understand that a fundamental step in your analysis is to figure out the value for the claims. You have to assign a value for the claims, correct?
A. The only thing that troubles me about your question is "fundamental." I don't know what you mean by "fundamental" in this context. It is a step in the calculation, but I don't know how to use the word "fundamental."
Q. That's fine. I'm not trying to use the word in any particular way. I'm just trying to make sure I understand the basic steps in the method here. So you have to derive a value for the claims, correct?

of increase on page 14. But in the text above Table 4 it identifies the rate of increase of 2.14 which is simply taken by -- derived by taking the 2000/2001 average settlement and dividing by the 1997/'98 settlement. That generates 2.14. We then multiply the 2000/2001 average by 2.14, and that generates a $210,000 figure.

Q. So you generate an estimate of the -- you call it the current settlement value of T&N mesothelioma claims as 210,000, plus a little bit, right?

A. Yes.

Q. And then you do not perform a similar calculation for other diseases, correct?

A. That's correct.

Q. Instead, you use a ratio to determine your average settlement values for other diseases, right?

A. We use several alternative ratios, yes.

Q. And those ratios are ratios of payments for other diseases to the average mesothelioma settlement values, correct?

MR. FINCH: Object to form. I think --

THE WITNESS: Yes, let me be specific. For lung cancer -- if you look on Table 5, page 15, it gives ratios for eight different asbestos defendants. And in each case for each of those defendants those numbers are derived by dividing the average settlement for that company for the diseases identified in the columns on Table 5 by the average settlement for mesothelioma for that defendant. And that generates those eight ratios.

BY MR. STROCHAK:

Q. And what you've done here is you've generated a ratio that links the payments or the anticipated settlement values for other diseases to mesothelioma, right?

A. Yes. It reflects the relative size

of settlements for diseases other than mesothelioma relative to what the mesothelioma settlements are for each of the eight defendants, yes.

Q. And after you go through that exercise of calculating those values, which I think are reported in Table 6 of your report; is that right?

A. For using -- it has three specific calculations based on ratios from Babcock & Wilcox, from Owens Corning and then what's essentially kind of a modal or a median approximation typical -- which also are numbers that are tossed about generally by people that do work like I do and work with trusts and generally are familiar with what the -- what payments are being made for asbestos claims.

This notion of ratios is a commonly used concept and it has been used in the past and is used by people that deal with asbestos claims in order to kind of understand what's

been happening with regard to the payments.

Q. I don't understand what you said.

You said something about numbers being tossed around. I didn't understand that part of your answer. What were you referring to when you said something was tossed around?

A. I'm sorry. That's a flip statement. Ratios like this are frequently discussed by the subcommunity of people who deal with arcane issues, such as what are the values of asbestos claims -- people like experts, judges, trust representatives, plaintiffs' lawyers. They attend to and are interested in what are the relative payments made to each of the disease categories.

And so it's a subject matter of some discussion, and it's a subject matter -- it's a calculation that has been used by courts and experts in other circumstances to set up trust distribution procedures, among other things, to estimate liabilities in bankruptcies and so on.

dollars, yes.

Q. That's a much better way of saying it than I did.

And that gives you your average resolution cost in 2001 dollars, which then goes into your calculations, right?

A. That's right.

Q. So now we've, I think at least at the 50,000-foot level, covered your basic calculation of claim value. But in order to derive an estimate, you also have to figure out how many claims you've got, right?

A. Yes.

Q. And then you go through a whole series of calculations to figure out how many claims can be anticipated in the future, right?

A. Well, you also have to deal with the pending claims, of course, because every one of the pending claims is here today and needs to be paid or not paid depending upon -- some percentage of them will get -- will be

dismissed; some will get paid.

Q. So with respect to the pending claims, you have an issue with -- certain claims in the database have no disease specified, correct?

A. Some do, that's correct.

Q. And you have --

A. Some have no specified diseases.

Q. Then you have to do an imputation to figure out what diseases should be attributed to those claims, right?

A. Both for the pending claims and for the claims that have been resolved, yes. You need to make the imputation for all of the claims that are going to figure into the analysis.

Q. And so for pending claims, you do your disease imputation. You figure out, then, how many claims of each disease you have, right?

A. Well, you have some -- for most claims, you have it, you count it. For those

that have an unspecified disease -- most of the claims that have an unspecified disease, we impute a disease for them. But we retain -- a relatively small percentage -- I think it's 2 or 3 percent of the claims -- we continue to treat as having unspecified. And that's a fraction that's the same as, historically, the percent of claims that were resolved with having an unspecified disease. Those claims don't get much money, so -- they have everything treated as its own category.

Q. But the basic process is to get all your claims that you see in the database -- that is, all the pending claims that you see in the database -- to get them into four separate buckets, so to speak, of diseases. You've got mesothelioma, lung cancer, other cancer and nonmalignant claims, correct?

A. With the one addendum to your question that we do retain a small fraction in the unspecified disease. So it's five categories, of which -- and all five are given

values for the pending claims, although the value of unspecified claims is zero.

For forecasting future claims, we do not forecast a number of unspecified claims, so that -- the implication of that is that there will be some additional claims filed against this defendant that will have an unspecified disease, and those claims would likely involve some defense and administrative costs, which -- we're ignoring that subject entirely in this report.

So there will be a few additional claims, but since they have no value, we have not bothered to calculate that number for purposes of estimating the indemnity costs for this.

Q. And then you multiply your -- for the number of pending claims you find in each disease, you multiply that by your calculated average resolution cost, correct?

A. That's the next step, yes.

Q. And that yields an indemnity cost

for each disease, correct?

A. It has a total cost of indemnification in nominal dollars for each of the four disease categories, yes -- for each of the four disease categories that get any money.

Q. And then how do you adjust the nominal dollar claim -- or let me ask you, do you make an adjustment to the nominal dollar amounts?

A. Yes.

Q. And what adjustment is that?

A. I believe we assume that half of the pending claims would be resolved -- would have been resolved in 2002 and half in 2003. So we give them an inflation -- we use the actual inflation in those two years to adjust those payments, to increase them to get the real values in each of those two years. And then when we do present value calculations, of course we present value them back to 2001 dollars.

Q. And that gives you your estimate for the pending claims, correct?

A. Yes. I mean -- yes, it does, and they're shown later in this section.

Q. Now, on the future claims, starting with the malignant claims, you calculate an incidence rate for each disease, correct?

A. No.

Q. How do you start with that? How do you start on the futures?

A. We accept the incidence rates that were estimated by Nicholson, Perkel, P-e-r-k-e-l, and Selikoff, S-e-l-i-k-o-f-f, in their 1982 publication where they make epidemiological forecasts of asbestos-related cancer deaths in -- year by year. So we don't do a calculation.

Q. You just take the Nicholson numbers?

A. We take published confirmed -- empirically confirmed forecasts of incidence of disease, yes.

Q. And incidents is -- that is, the Nicholson incidence forecasts are forecasts of the number of people who will die from each of these categories of diseases in a particular year; is that right?

A. Well, not quite. It's the number of people who will die because of their occupational exposure to asbestos. There are clearly going to be many more lung cancer deaths than lung cancer deaths caused by asbestos in a year.

And also the Nicholson number, again -- it's called Nicholson for shorthand. I will use that term. The Nicholson numbers are a bit conservative because they exclude two categories of persons who will die from asbestos-related cancers. One category is that there are occupational -- there are industries that they didn't consider, and so there is a broader category of industries where there were occupational exposures to asbestos. The Manville trust has kind of

maintained some data with regard to the claims they received from what they call the Nicholson industries and the other industries, and there are a nontrivial number of cancers that arise in that group.

And secondly, the Nicholson epidemiological forecasts were based on exposures through 1979. People continue, unfortunately, to be exposed to asbestos today. There are people who are going to be exposed to asbestos today who will die from asbestos-related cancers in future years. That number, fortunately, is likely to be much smaller than the deaths that arose and will arise from exposures prior to 1980, but there will be some.

So in both of those respects, the Nicholson forecasts are likely a bit conservative, but probably not greatly undercounted. And that may be more likely to be apparent 10, 15 years in the future when some of these, you know, later-arising

exposures begin to manifest --

Q. So starting with the incidence of -- and I appreciate your correction that it's really -- it's incremental deaths due to asbestos exposure, not total deaths due to these diseases. But starting with the forecast incidence rates of incremental deaths due to asbestos exposure, you then calculate what you call propensity to sue, correct?

A. We use the Nicholson incidence estimates and calculate propensities to sue.

Q. And what you do is -- to calculate propensity to sue, again, at the 50,000-foot level -- and feel free to add as much detail as you would like to this -- you compare the number of filings that you see in the T&N database for a particular period to the Nicholson incidence numbers for that particular period for the same disease; is that right as a general conceptual framework?

A. Yes.

Q. So your calculation of propensity

to sue is a comparison of filings in a given year to incidence in a given year, right?

A. Yes. Of course it's filings subject to the -- yes. And I will -- yes, that's correct.

Q. And then once you have your propensity to sue -- that is, once you've calculated what you view as the historical propensity to sue, you have two models in your report, one forecasting future propensity to sue on an increasing basis, and one forecasting future propensity to sue on what I will call a flat basis; is that a fair characterization?

A. Yes, where the flat basis is using the -- essentially the weighted average propensity to sue for the two years we used to calculate, 2000 and 2001 -- actually, the 21 months we used to calculate in 2000 and 2001.

Q. That's your base period --

A. That's the base period.

Q. -- the 21 months?

A. I'm sorry. I talked over you. That's correct.

Q. I do the same. I'm sorry.

So once you've now derived your projections of propensity to sue, you multiply the propensity to sue -- well, let me ask you. What do you do with propensity to sue, your forecast propensity to sue, once you've calculated it? What's the next step in the calculation?

A. Well, the first thing we do when we calculate a propensity to sue is we calculate it year by year within each of the three cancers separately. So then we examine the trends of propensity to sue.

Before we do anything else, we look at the data. I mean, always you look at what information you've got. And the data confirm what we've learned in the discussions with the lawyers and all the other things I was describing earlier, the background work that

we did based upon our understanding and knowledge about what was going on with asbestos litigation generally, what was happening with regard to Turner & Newall, what were the important developments in the asbestos litigation that affected Turner & Newall.

We looked at the data and saw that the data was consistent with our expectations that claims were going up. And so that's the first thing you do.

And based on that, we then made these two calculations of -- we selected a base period. We selected the appropriate base period, which was 2000/2001. Because claims are going up -- well, let me interject a prefatory remark as to why we used propensities to sue. You use propensities to sue under the assumption that the future claiming rate -- claim filing will be similar to what it has been in the past. "The past is prolog" is kind of a mantra that people like

me use in doing work like this.

And the two things you learn from propensities to sue is, one, what is the level of claiming against this defendant? And, two, what are the trends in the level of claiming? Those are the quantitative data conclusions. You compare that with what you know about asbestos litigation.

Based upon that, you then need to select what's the appropriate period -- base period. Since you want to forecast the future, you want to take a period of time that you believe is most like what the future will be. That's why we picked the last 21 months.

If you go further back in time, it gets decreasingly similar to the current circumstances. And also when you've got an increasing trend, the further back in time, the lower your average would be across years, which does not represent what's happening now. That's why you need a relatively current base period.

So we've picked that base period. That's the next step. And then, having done that, we generate both the increasing forecast, and then just as kind of -- for purpose of calculation, also look at the nonincreasing just to see what would happen if things were frozen.

If this trend for increasing suddenly reversed and didn't go up anymore today, what would it be? It's almost more a calculation done for numeric purposes rather than because we think it's likely to happen, that there will be no increase in propensity to sue.

But then we -- so that generates for us each future year what we -- these two alternative models of what the propensities to sue will be under the increasing model and the flat model. And then we take that propensity to sue that we've forecast for each future year and multiply it by Nicholson incidence forecasts of the number of people who will die

of that cancer in the year, multiplying the propensities to sue times the incidence figure. The product of that multiplication is the estimated forecasts of the number of claims for that cancer that will be filed in that year.

Q. And your calculations are done -- your calculations of propensity to sue are done on a disease-by-disease basis; is that right?

A. For each of the three cancers, yes.

Q. Is that standard practice?

A. You always do it that way unless you don't have data disaggregated or for some other reason, but that's the standard practice, yes.

Q. So, typically, if you have data that would allow you to forecast -- excuse me. If you have data that would allow you to calculate propensity to sue on a disease-by-disease basis, it would be better to do so?

A. Yes, because the incidence curves differ by disease, so you get a more precise forecast, and hopefully a more accurate forecast if you do it disease-by-disease.

Q. Is that true only for propensity to sue or is it true for other measures used in liability forecasting?

MR. FINCH: Object to form.

THE WITNESS: It is also true, of course, for calculating average values because the average values differ by disease. So you want to disaggregate the claims by disease categories. In order to do that, the payment rate -- the payment percentages also differ somewhat by the disease, so it's useful to disaggregate it.

BY MR. STROCHAK:

Q. So once you've calculated your -- or projected your propensity to sue, that gets multiplied on a disease-by-disease basis against the incidence forecast derived from -- or taken from the Nicholson study, correct?

A. Yes.

Q. And then that would give you the number of claims you would anticipate in each future year; is that right?

A. For each cancer, yes.

Q. For each disease, right.

And then once you have the number of claims, you then perform a calculation to figure out how much value to assign to each one, right?

A. Yes.

Q. And that's your average value calculation that we talked about before?

A. Specifically, we use the average resolution cost, which itself is the product of the average settlement times the percent paid. So in effect you're multiplying the number of claims by two parameters: What percentage of them get paid, and how much will they get paid if they do get paid.

But we've reduced that to a single parameter: The average resolution cost. And

subject, of course, to future inflation. So that someone who gets paid ten years in the future would get paid at 1.025 to the 10th power times whatever this value is. That's inflation that occurs over that period of time.

Q. So you inflate the values out to the current -- to the applicable year, and then ultimately you discount your calculation back to present value, right?

A. Yes. Actually, we assume that future claims get paid two years in the future. So if a claim is filed -- I misspoke. If a claim is filed in 2010, we inflate it to 10.025 to the 12th power because it goes up -- they will get paid 12 years in the future even though they filed 10 years in the future. And you discount it back for 12 years.

MR. STROCHAK: This is a good place for a five-minute break.

(Recess.)

BY MR. STROCHAK:

Q. Dr. Peterson, I would like to turn back to your report and go through it in a little more systematic way, page by page of your report. So starting on page 1, at the end of the first paragraph you talk about your forecasts and you talk about the estimates in this report being based on forecasting models that have become a standard model for making such forecasts. Is that a fair statement of what you're saying there?

A. Yes.

Q. Is it your opinion, sir, that the methods that you've used in this report are standard across all experts who are forecasting asbestos claims?

A. I don't understand your question.

Q. The specific methods that you've used in your report, are all of them standard?

MR. FINCH: Object to form.

THE WITNESS: Well, some of them are specific to this company. It's the application of a standard method to the